



**Renewal Application  
for HIV Health and Social Services  
(State Services)  
Subgrants**

**Issue Date: February 28, 2003**

**Project Period: September 1, 2003 – August 31, 2004**  
**Application Due Date: April 30, 2003**

Bureau of HIV and STD Prevention  
<http://www.tdh.state.tx.us/hivstd>  
1100 W. 49<sup>th</sup> Street  
Austin, Texas 78756-3199

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George McCleskey, B.B.A., J.D.  
Chair, Texas Board of Health

Eduardo J. Sanchez, M.D., M.P.H.  
Commissioner

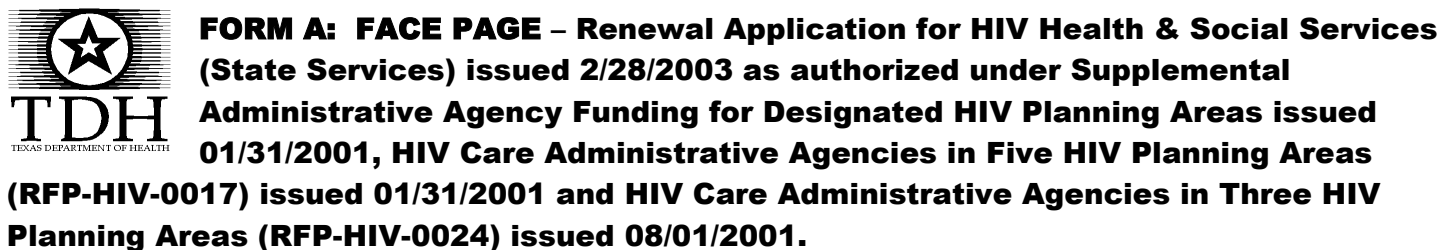
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**APPLICATION CHECKLIST  
STATE SERVICES RENEWAL APPLICATION**

- \_\_\_ Application Checklist (this page)
  - \_\_\_ Form A: Face Page – Renewal Application for HIV Health & Social Services (State Services)
  - \_\_\_ Form C: Program Contact Information
  - \_\_\_ Form D: Administrative Information
  - \_\_\_ Categorical Budget and Justification  
(Created by Applicant – Sample Format Included)
  - \_\_\_ Form G-3: Equipment – Budget Category Detail Form
  - \_\_\_ Justification for Request for Equipment Purchases
  - \_\_\_ Vendor Certification for Computer Equipment purchased by TDH Contractor  
(if applicable)
  - \_\_\_ Table 1A: Services Priorities and Objectives by Health Service Delivery Area (HSDA)
  - \_\_\_ Table 1B: Services Priorities: Administrative Agency Summary Sheet for all HSDA's
  - \_\_\_ Form H: Nonprofit Board of Directors and Executive Director Assurances Form  
If the signed original of this form has been provided to the Texas Department of Health during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.
  - \_\_\_ Form L: HIV Contractor Assurances
  - \_\_\_ Form M: Contractor Assurance Regarding Pharmacy Notification
  - \_\_\_ Form N: Assurance Regarding HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services
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Only include the forms below if different from the State Services application submitted for 2002.

- \_\_\_ Form E: Performance Measures
- \_\_\_ Form F: Work Plan



APPLICANT INFORMATION	
<b>1) LEGAL NAME:</b>	
<b>2) MAILING Address Information</b> (include mailing address, street, city, county, state and zip code): <span style="float: right;">Check if address change <input type="checkbox"/></span>	
<b>3) PAYEE Mailing Address</b> (if different from above): <span style="float: right;">Check if address change <input type="checkbox"/></span>	
<b>4) Federal Tax ID No.</b> (9 digit) or <b>State of Texas Comptroller Vendor ID No.</b> (14 digit):	
<b>5) TYPE OF ENTITY</b> (check all that apply): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> City</div> <div style="width: 33%;"><input type="checkbox"/> Nonprofit Organization*</div> <div style="width: 33%;"><input type="checkbox"/> Individual</div> <div style="width: 33%;"><input type="checkbox"/> County</div> <div style="width: 33%;"><input type="checkbox"/> For Profit Organization*</div> <div style="width: 33%;"><input type="checkbox"/> State Controlled Institution of Higher Learning</div> <div style="width: 33%;"><input type="checkbox"/> Other Political Subdivision</div> <div style="width: 33%;"><input type="checkbox"/> HUB Certified</div> <div style="width: 33%;"><input type="checkbox"/> Hospital</div> <div style="width: 33%;"><input type="checkbox"/> State Agency</div> <div style="width: 33%;"><input type="checkbox"/> Community-Based Organization</div> <div style="width: 33%;"><input type="checkbox"/> Private</div> <div style="width: 33%;"><input type="checkbox"/> Indian Tribe</div> <div style="width: 33%;"><input type="checkbox"/> Minority Organization</div> <div style="width: 33%;"><input type="checkbox"/> Other (specify): _____</div> </div>	
<i>*If incorporated, provide 10-digit charter number assigned by Secretary of State:</i>	
<b>6) Currently operating under a HUB Subcontracting plan on file at TDH?</b> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>	
<b>7) PROPOSED BUDGET PERIOD:</b> <span style="margin-left: 100px;"><b>Start Date:</b></span> <span style="float: right;"><b>End Date:</b></span>	
<b>8) COUNTIES SERVED BY PROJECT:</b>	
<b>9) AMOUNT OF FUNDING REQUESTED:</b>	<b>11) PROJECT CONTACT PERSON</b>
<b>10) PROJECTED EXPENDITURES</b> Does applicant's projected state or federal expenditures exceed \$300,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? ** <div style="text-align: center; margin-top: 10px;">                     Yes <input type="checkbox"/> No <input type="checkbox"/> </div> <div style="font-size: small; margin-top: 10px;"> <i>**Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related TDH funds.</i> </div>	Name: Phone: Fax: E-mail:
<b>12) FINANCIAL OFFICER</b>	
Name: Phone: Fax: E-mail:	
I, the undersigned, am the authorized representative of the applicant filing this contract renewal application. The facts contained herein are true, and the applicant is in compliance with the assurances and certifications contained in the competitive RFP identified above, which is part of the original contract and any prior renewals and amendments. I understand that this contract renewal depends on the truthfulness of this document and on the applicant's continued compliance with the original contract and all its components and amendments.	
<b>13) AUTHORIZED REPRESENTATIVE</b> Name: Phone: Fax: E-mail:	<b>14) SIGNATURE OF AUTHORIZED REPRESENTATIVE</b>  <b>15) DATE</b>

## FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the Texas Department of Health (TDH), including the signature of the authorized representative. It is the cover page of the renewal application and required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original TDH contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

- 1) **LEGAL NAME** - Enter the legal name of the applicant.
- 2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.
- 3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit).
- 5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the General Services Commission or another entity.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

- 6) **CURRENTLY OPERATING UNDER A HUB SUBCONTRACTING PLAN ON FILE AT TDH? Yes or No** – Check the appropriate box to indicate whether or not the applicant is operating under a HUB Subcontracting Plan filed with TDH under the original competitive RFP. If yes, the applicant must continue to comply with reporting requirements if a renewal contract is executed. Any changes to the budget which affect the HUB Subcontracting Plan must be communicated with the TDH HUB Coordinator at 1-800-243-7487 or by e-mail at [al.beavers@tdh.state.tx.us](mailto:al.beavers@tdh.state.tx.us). If no is checked, no further action is required.
- 7) **PROPOSED BUDGET PERIOD** - Enter budget period as identified in this renewal application.
- 8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.
- 9) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding requested from TDH for proposed project activities. This amount must match column (1) row K from FORM I: BUDGET SUMMARY.
- 10) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed \$300,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).
- 11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.
- 12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.
- 13) **AUTHORIZED REPRESENTATIVE** - Enter the name, phone, fax, and e-mail address of the person authorized to represent the applicant.
- 14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant signs in this blank.
- 15) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

## FORM C: PROGRAM CONTACT INFORMATION

Legal Name of Applicant: \_\_\_\_\_

*This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify the program.*

<b>Contact:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b>
<b>Title:</b> _____	_____
<b>Phone:</b> _____	_____
<b>Fax:</b> _____	_____
<b>E-mail:</b> _____	_____
<b>Contact:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b>
<b>Title:</b> _____	_____
<b>Phone:</b> _____	_____
<b>Fax:</b> _____	_____
<b>E-mail:</b> _____	_____
<b>Contact:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b>
<b>Title:</b> _____	_____
<b>Phone:</b> _____	_____
<b>Fax:</b> _____	_____
<b>E-mail:</b> _____	_____
<b>Contact:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b>
<b>Title:</b> _____	_____
<b>Phone:</b> _____	_____
<b>Fax:</b> _____	_____
<b>E-mail:</b> _____	_____
<b>Contact:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b>
<b>Title:</b> _____	_____
<b>Phone:</b> _____	_____
<b>Fax:</b> _____	_____
<b>E-mail:</b> _____	_____

## FORM D: ADMINISTRATIVE INFORMATION - Renewal Application

*This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information **or provide the required supplemental document behind this form.** If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

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**Legal Name of Applicant:** \_\_\_\_\_

### **Identifying Information**

If there are no changes to any of the items below, check here and skip the next question in this section.

☐

**1. The applicant shall attach the following information:**

**If a Governmental Entity**

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

**If a Nonprofit or For profit Corporation**

- Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate what offices are held by members (e.g. chairperson, president, vice-president, treasurer, etc.).
- Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if applicant is a for profit corporation.

### **Conflict of Interest and Contract History**

If there are no changes to any of the items below, check here and skip the questions in this section.

☐

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this renewal application. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with TDH, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this renewal application. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of TDH, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination. If, following a review of this information, it is determined by TDH that a conflict of interest exists, the applicant may be disqualified from further consideration for the renewal of a contract.

**1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this renewal application?**

☐ YES      ☐ NO

*If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)*

**2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the renewal application due date?**

☐ YES      ☐ NO

*If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.*

## FORM D: ADMINISTRATIVE INFORMATION – continued

**3. Is applicant or any member of applicant's executive management, project management, board members or principal officers:**

- delinquent on any state, federal or other debt;
- affiliated with an organization which is delinquent on any state, federal or other debt; or
- in default on an agreed repayment schedule with any funding organization?

☐ **YES**      ☐ **NO**

*If YES, please explain. (Attach no more than one additional page.)*

## INSTRUCTIONS AND EXAMPLES FOR A CATEGORICAL BUDGET & JUSTIFICATION

**TOTAL**

### **A. PERSONNEL**

**(Total)**

[List each position. Give a brief job description of 50 words or less. For each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months that the salary is to be paid from this budget.]

**Example:**

**Executive Director (Gonzales)**

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Oversees all program activities. Ensures compliance with contract requirements. Provides program/financial information to the Board of Directors. Acts as agency personnel director and public spokesperson. supervises Program Manager.

**Bookkeeper (Jones)**

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Performs full charge bookkeeping duties. Inputs transaction data and produces general ledger, income/expense statements and balance sheets. Maintains and produces payroll. Checks invoices for accuracy and prepares them to be approved for payment. Prepares accounts payable.

**Program Manager (Watson)**

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Supervises Prevention Counselor and Outreach Educator. Provides needed staff training. Coordinates prevention programming. Designs and maintains data collection system. Prepares all required program reports. Evaluates staff performance and conducts quality assurance.

**HIV Prevention Counselor (McDade)**

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Conducts HIV prevention counseling and testing through street outreach targeting IDUs, sex partners of IDUs and females who sell sex for drugs or money. collect and maintain accurate program data. Make appropriate referrals for services. Distribute condoms. Performs partner elicitation activities with HIV-positive clients.

**HIV Prevention Counselor/Outreach Educator (Vacant)**

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Conducts street outreach with UHS high-risk adolescents. Does one-on-one and small group education and risk reduction skills training at appropriate sites (hang-out street corners, juvenile detention centers, youth shelters). Provide prevention counseling and testing at these same locations. Conduct partner elicitation. Collect and maintain accurate program data. Make appropriate referrals for services. Distribute condoms.



TOTAL

Outreach Educator (New position) (attach Job description)

\$\_\_\_\_\_/monthly X 100% X 12 = \$\_\_\_\_\_

Conduct street outreach and small group activities with MSMs of Color. Conduct one-on-one risk reduction and education at bars, public sex environments, and other places the population congregates. Provide risk-reduction and self-esteem building small groups. Distribute condoms and make referrals. Design literature which is language and culturally appropriate. Collect and maintain accurate program data.

**B. FRINGE BENEFITS**

(Total)

[Itemize the cost of fringe benefits paid for employees, including employer contributions for Social Security, retirement, insurance and unemployment compensation. Fringe benefits requested must represent the actual benefits paid for employees.]

Example:

FICA: \_\_\_\_\_ x \$\_\_\_\_\_ = \$\_\_\_\_\_

Insurance: \$\_\_\_\_\_ x 3.55 FTEs = \$\_\_\_\_\_

Worker's Comp: rate x salaries = \$\_\_\_\_\_

Unemployment: rate x salaries = \$\_\_\_\_\_

**C. STAFF TRAVEL**

(Total)

[Budget the projected costs of transportation, lodging, meals, and related expenses for official staff business travel conducted in carrying out the contract. Out of state travel is only allowed with pre-approval from the TDH. Costs for travel to the bi-annual Texas HIV/STD Conference Austin should be included, if applicable. NOTE: Grantees who do not have written travel reimbursement policies must use TDH travel reimbursement rates as follows: \$.35/mile, \$30/day meals, \$80/day lodging.]

Example:

Mileage for Prevention Counselors in service area:

\$0.35/mile X \_\_\_\_\_ miles/mo. X 12 months - \$\_\_\_\_\_

Mileage for Outreach Educators in service area:

\$.35 mile X \_\_\_\_\_ miles/mo. X 12 months - \$\_\_\_\_\_

Expenses for 3 staff members to attend Texas HIV/STD Conferences:

Airfare @ \$\_\_\_\_\_ X 3 staff = \$\_\_\_\_\_

Lodging @ \$\_\_\_\_\_ X 4 days X 3 staff = \$\_\_\_\_\_

Meals @ \$\_\_\_\_\_ X 4 days X 3 staff = \$\_\_\_\_\_

**D. EQUIPMENT**

(Total)

[Equipment is defined as tangible non-expendable property with an acquisition cost of over \$1000, including freight, and a useful life of more than one year, with the following exceptions: costs for FAX

machines, stereo systems, cameras, video recorder/players, microcomputers, and printers with a unit cost of \$500 or more. Prior written approval from the TDH is required before grantee may acquire equipment. List each item, describe and explain use. Attach the Justification for Request for Equipment Purchase form for each piece of equipment requested.

**E. SUPPLIES**

**(Total)**

[This category is for the costs of materials and supplies necessary to carry out the project. It includes general office supplies, janitorial supplies, and any equipment with a purchase price, including freight, of less than \$1000 or less per item.]

**Example:**

General office supplies - \$ \_\_\_\_\_ mo x 12 mo

\_\_\_\_\_

Education Supplies - \$ \_\_\_\_\_

\_\_\_\_\_

Includes: supplies for safer sex kits (lubricants, oral sex condoms, female condoms, etc.)

Phlebotomy supplies - \$ \_\_\_\_\_

\_\_\_\_\_

**F. CONTRACTUAL**

**(Total)**

[DEFINITION: Whenever the applicant intends to delegate part of the activities identified in the scope of work to a third party, the cost of providing these activities is recorded in this category. Travel by these individuals should be included in this category if they are delivering client services. Contracts for administrative services are not included in this category; they are properly classified in the Other category.]

If the applicant enters into grant contracts with subrecipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Subrecipients and Contracts for Procurement articles in the General Provisions for Texas Department of Health Grant Contracts available online at [www.tdh.state.tx.us/grants/forms\\_and\\_documents.htm](http://www.tdh.state.tx.us/grants/forms_and_documents.htm) or by calling Grants Management Division at 512-458-7470.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., \$25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to TDH and receive prior written approval from TDH before entering into the contract.]

**G. OTHER**

**(Total)**

[DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

- \* contracts for administrative services;
- \* space and equipment rental;
- \* utilities and telephone expenses;

- \* data processing services;
- \* printing and reproduction expenses;
- \* postage and shipping;
- \* contract clerical or other personnel services;
- \* janitorial services;
- \* exterminating services;
- \* security services;
- \* insurance and bonds;
- \* equipment repairs or service maintenance agreements;
- \* books, periodicals, pamphlets, and memberships;
- \* advertising;
- \* registration fees;
- \* patient transportation;
- \* training costs, speakers fees and stipends.

#### **H. TOTAL DIRECT COSTS**

**(Total)**

[Enter the total of A - G above]

#### **I. INDIRECT COSTS**

**(Total)**

[A copy of the current negotiated indirect cost rate must be attached, if applicable. If there is no negotiated rate, applicant may recover up to 10% of the direct salary and wage costs of providing the service, excluding overtime and fringe benefits, subject to adequate documentation of salary and wage costs.]

#### **J. TOTAL BUDGET**

**(Total)**

## FORM G-3: EQUIPMENT Budget Category Detail Form

Legal Name of  
Applicant: \_\_\_\_\_

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (≥ \$1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		\$ 0.00	

# SAMPLE 3-3: EQUIPMENT Budget Category Detail Form Sample

Legal Name of  
Applicant: Apple County Health Department

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order.

DESCRIPTION OF ITEM (≥ \$1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHZ, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory	\$2,060 / 1	\$2,060	Administrative processing and billing for Community Power Point presentation on the value of Family Planning
TOTAL Amount Requested for EQUIPMENT:		\$ 2,060	

## EQUIPMENT

DEFINITION: Equipment is defined by TDH as non-expendable personal property with a unit cost of more than \$1,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over \$1,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is \$500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the \$500/\$1,000 threshold.

INSTRUCTIONS: Enter the following information on the EQUIPMENT Budget Category Detail Form for each type of equipment item: description of each item, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), state the purpose for the item(s) and why the equipment is necessary and how the applicant determined or will determine that the cost is reasonable. Attach a complete specification or a copy of the purchase order.

### EXAMPLES OF EQUIPMENT DESCRIPTIONS

**Remember:** Equipment is priced **per unit** including freight. If you intend to purchase 10 modems @ \$95 each, this would be considered a supply item not an equipment item.

#### INCORRECT EXAMPLES

Computer-850 Mhz Pentium  
Internal Cache (L1), 100 MHZ (Pentium III)  
1 @ \$2,150  
Chipset with 4X AFP memory.  
*(insufficient description/specification)*  
1 @ \$250 Laser Jet Printer  
*(This item would be moved to supplies  
as it is less than \$500.00).*

#### CORRECT EXAMPLES

Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHZ, .32 KB  
external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set  
1 @ \$2,150  
24" Zenith Portable TV/VCR Combination;  
Model #Z12345  
1 @ \$750

<b>JUSTIFICATION FOR REQUEST FOR EQUIPMENT PURCHASES</b>
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**Instructions:** Use one Justification form for each item listed on the Equipment List. For equipment over \$25,000, complete this form and the Justification for Equipment over \$25,000. Attach copies of specifications and/or other pertinent documentation. For computer equipment, complete specifications must be attached.

**Contractor Name:** \_\_\_\_\_

**Scope of Work:** \_\_\_\_\_

**Contract Number:** \_\_\_\_\_ **Contract Term:** \_\_\_\_\_

**Description of Equipment Requested (attach additional sheets if necessary and copies of specifications and/or other pertinent documentation):**

<b>ALL APPLICANTS MUST COMPLETE THIS SECTION:</b>
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1. Does the cost include shipping and handling?
2. Does the cost include a warranty?
3. Does the cost include a maintenance agreement? Describe any special maintenance needs, service contracts, insurance, repair costs, etc. related to the proposed equipment. How will these expenses be supported over time?
4. Does the cost include training in the use of the equipment?
5. Why is the equipment needed? What is the purpose of the equipment?
6. Estimate the expected results of the equipment purchase. Who will benefit and how?

7. How many clients will be served with the equipment?
8. What administrative or other activities will be accomplished as a result of the equipment purchase?
9. Where will it be located?
10. Who will use the equipment? Are the necessary staff in place to support the proper use of the equipment (e.g., if a van is requested, is there funding already in place to pay for a driver)?
11. Will the equipment replace any existing equipment? If so, please justify the replacement of existing equipment.
12. Will the equipment be purchased and owned by the administrative agency or by one of its current subcontractors?
13. Why is this equipment more appropriate than other alternatives considered or a less expensive piece of equipment? If the equipment has special or optional features, explain why they are necessary.
14. If the equipment is a lease-to-purchase agreement, is a copy of the agreement attached?
15. If the equipment is being leased with no option to buy, explain the benefit(s).
16. If lease-purchase costs are spread across several funding sources, other than TDH, who are the other funding sources and what is their percent of funding?

**HIV SERVICES PROVIDERS ONLY:**

17. If equipment is for an Administrative Agency or its subcontractor, does it match the service priorities established by the local consortia? Will the equipment be used to directly provide a prioritized client service? If not, how will the equipment either indirectly support client services and/or support necessary administrative functions?
18. If requesting computer equipment, does the program use the COMPIS program?

19. If yes, what is the memory capacity of the computer equipment currently used for COMPIS activity?
20. Does the computer requested have a larger memory capacity than the current COMPIS equipment?
21. What enhancements will the new computer(s) provide?



## Minimum Computer Equipment Specifications

The following table contains minimum computer equipment specifications required for computer equipment purchases approved by the Bureau of HIV and STD Prevention. Please see notes on the next page for additional requirements.

Bureau of HIV and STD Prevention Minimum Computer Equipment Specifications (9/3/2002)
Intel Pentium microprocessor, 1.80 GHz
256 Mb SDRAM, 512K cache
11 Mb AGP video RAM
20 Gb 7200 RPM EIDE or SCSI boot hard drive
PCI EIDE or PCI SCSI hard drive controller
1.44 Mb 3.5" floppy diskette drive
EIDE CD ROM drive (48X speed or higher)
2 serial ports (16550AF UART) and 1 parallel port
Mouse, Microsoft or compatible
Microsoft Windows 2000 operating system or higher
17" SVGA monitor, .28 mm dot pitch, 1024 x 768 resolution
1 year parts & on site labor warranty (recommend 3 year extended warranty for parts)
Sound card and speakers (recommend Sound Blaster compatible.)
Optional: V.92 modem (recommend U.S. Robotics/3Com compatible.)

Please see notes on next page for additional requirements.

**Notes:**

- a.) A complete system price shall not exceed \$1,682 for a desktop system / \$2,200 for a laptop system. Please submit justification when the purchase cost for a system exceeds these limits.
- b.) When contractor budgets are prepared to purchase computer equipment, complete computer equipment specifications, including printers, must be submitted to TDH.
- c.) Vendors who assemble systems with generic (clone) computer parts or upgrade components must complete and submit the attached vendor certification to the quote and equipment specifications the vendor presents to the TDH contractor. The vendor's certification must be submitted to TDH along with the contractor's budget to purchase computer equipment.
- d.) Due to market volatility, the pricing of computer equipment or peripherals may fluctuate greatly within weeks. The TDH considers vendor quotations issued greater than 30 days from the current date to be expired or non-current. A TDH contractor should submit current vendor specifications and quotations to the TDH with their requests to purchase equipment.

If you need additional information, please contact Alex T. Nghiem, Manager, Information Systems Branch at 512-490-2550.

## **Vendor Certification for Computer Equipment purchased by TDH Contractor**

(Please attach to Vendor's computer equipment quote and specifications.)

- 1.) All equipment components shall be new at time of purchase, of current production, and shall include the manufacturer's standard equipment, accessories (power cords, cables, etc.) and component documentation.
- 2.) All equipment components shall be one hundred percent (100%) compatible with IBM microcomputers, capable of running the same software, and capable of operating with add-on/options cards designed to run in IBM-compatible microcomputers.
- 3.) All equipment shall be certified 100% Microsoft Windows 2000 and Novell Netware 5.1 compatible. All equipment purchased for use as network file servers shall be Microsoft/National Software Testing Laboratories-certified to operate Windows 2000 Advanced Server and Novell-certified to operate as a Netware 5.1 server.
- 4.) TDH is aware problems may develop in computer equipment due to heat generated by the components. The vendor must certify its computer system is designed in such a manner to allow for adequate heat dissipation and the vendor shall repair, replace, or add additional components to systems which have problems which are determined to be heat-related.
- 5.) TDH expects systems and equipment purchased by TDH contractors will be quality merchandise. Further, we expect the equipment will operate properly at the time of initial installation. TDH hereby establishes and defines Excessive Failure as a failure rate greater than one percent (1%) of the items specified and provided to a TDH contractor by the vendor which becomes non-operational and/or unusable during the course of normal operation. All problems must be repaired or replaced at the vendor's expense, including parts, labor, and any necessary freight or handling charges. If the vendor does not repair and/or replace the defective system(s)/component(s) within twenty-four (24) business hours of notification, the TDH and/or its contractor shall have the right to take whatever reasonable actions are necessary to repair and/or replace the defective system(s)/components(s), and shall have the right to recover from the vendor all expenses incurred from these actions. Intentional or accidental damage of any system(s) and/or component(s) caused by employees and/or clients and/or acts of nature to the equipment shall not be construed as failure for the purposes of this provision.

Authorized Vendor Signature / Date \_\_\_\_\_

Printed Name / Title / Phone \_\_\_\_\_

Company Name / Address \_\_\_\_\_

\_\_\_\_\_

**TABLE 1A: SERVICES PRIORITIES AND OBJECTIVES  
BY HEALTH SERVICE DELIVERY AREA (HSDA)**

**Administrative Agency Name:** \_\_\_\_\_

**Health Service Delivery Area:** \_\_\_\_\_

**Date of Service Delivery Plan:** \_\_\_\_\_

**Instructions:** Use this table to reflect the service priorities established as a result of your last needs assessment process. Place the ranking number of each prioritized service in Column 2. In Column 3 show number of units to be provided and in Column 4 show number of persons to be served. *NOTE: \*for an organization operating with unit cost, please only complete the "unit" column.* Assign a ranking only to those services you have prioritized. Leave the rest of the service categories blank. In Column 5 state the budget amount allocated to that service category, and in Column 6 indicate what percentage of the total Title II award is allocated to that service category.

\*\*\*{A Table 1B must be completed for EACH HSDA with the Administrative Agency's area}\*\*\*

SERVICES CATEGORY	PRIORITY RANKING	OBJECTIVE		RYAN WHITE/ TITLE II ALLOCATION FOR HSDA	% OF TOTAL RYAN WHITE/TITLE II ALLOCATION FOR HSDA
		Units*	Persons		
<b><u>Health Care Services</u></b>					
Ambulatory/Outpatient Medical Care				\$	
Dental Care				\$	
Health Insurance				\$	
Home Health: All categories of care.				\$	
Hospice Services: All categories of care.				\$	
Mental Health Counseling/Treatment				\$	
Nutritional Services				\$	
Rehabilitation Services				\$	
Substance Abuse Counseling/ Treatment				\$	
Treatment Adherence/Compliance				\$	
Other Health Services (attach sheet detailing services)				\$	
				\$	
Case Management				\$	
				\$	

<b><u>Support Services:</u></b>				\$	
Adoption/Foster Care Assistance/Permanency Planning				\$	
Buddy/Companion Services				\$	
Client Advocacy				\$	
Counseling (Other)				\$	
Day/Respite Care				\$	
Direct Emergency Financial Assistance				\$	
Food Bank/Home-delivered Meals/Nutritional Supplements				\$	
Health Education/Risk Reduction				\$	
Housing Assistance				\$	
Housing Related Services				\$	
Referral to Primary Care and Related Service				\$	
Transportation				\$	
Other Support Services (attach sheet detailing service)				\$	
				\$	
<b><u>Other Priorities:</u></b>				\$	
Capacity Building Initiatives				\$	
Needs Assessment/Planning/Evaluation				\$	
ADMINISTRATION				\$	
				\$	
<b><u>TOTAL</u></b>				\$	

<b>TABLE 1B: SERVICES PRIORITIES:</b> <b>ADMINISTRATIVE AGENCY SUMMARY SHEET FOR <u>ALL</u> HSDA's</b>
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**Administrative Agency name:** \_\_\_\_\_

**Instructions:** Use this table to summarize all allocations by service categories detailed in all Table 1B's for each Health Service Delivery Area (HSDA). In Column 2 state the cumulative budget amount allocated to that service category (all HSDA's served) and in Column 3 indicate what percentage of the total Title II award is allocated to that service category. NOTE: \*The TOTAL should match the total amount allocated to your Administrative Agency by TDH (based on the formulary.)

SERVICES CATEGORY	RYAN WHITE/ TITLE II ALLOCATION	% OF TOTAL RYAN WHITE/TITLE II ALLOCATION
<b><u>Health Care Services</u></b>	\$	
Ambulatory/Outpatient Medical Care	\$	
Dental Care	\$	
Health Insurance	\$	
Home Health: All categories of care.	\$	
Hospice Services: All categories of care.	\$	
Mental Health Counseling/Treatment	\$	
Nutritional Services	\$	
Rehabilitation Services	\$	
Substance Abuse Counseling/ Treatment	\$	
Treatment Adherence/Compliance	\$	
Other Health Services (attach sheet detailing services)	\$	
	\$	
Case Management	\$	
	\$	
<b><u>Support Services:</u></b>	\$	
Adoption/Foster Care Assistance/Permanency Planning	\$	
Buddy/Companion Services	\$	
Client Advocacy	\$	
Counseling (Other)	\$	
Day/Respite Care	\$	

Direct Emergency Financial Assistance	\$	
Food Bank/Home-delivered Meals/Nutritional Supplements	\$	
Health Education/Risk Reduction	\$	
Housing Assistance	\$	
Housing Related Services	\$	
Referral to Primary Care and Related Service	\$	
Transportation	\$	
Other Support Services (attach sheet detailing service)	\$	
	\$	
<u>Other Priorities:</u>	\$	
Capacity Building Initiatives	\$	
Needs Assessment/Planning/Evaluation	\$	
ADMINISTRATION	\$	
	\$	
<b><u>TOTAL**</u></b>	\$	

\*Glossary of HIV-Related Service Categories: *Administrative Agencies may find the Glossary at the Health Resources Services Administration (HRSA) web site, [www.hrsa.gov/hab](http://www.hrsa.gov/hab) for specific guidance on HIV related service categories.*

## FORM H: NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with TDH.

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Name & Address Of Organization)

The persons signing on behalf of the above named organization certify that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

- A. That an annual budget has been approved for each contract with TDH.
- B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.
- C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).
- D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.
- E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.
- F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.
- G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.
- H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.
- I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.
- J. If a contract is executed with the Texas Department of Health, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be forwarded to the Texas Department of Health's Grants Management Division, no later than 45 days after the meeting in which the form was discussed.
- K. If a contract is executed with the Texas Department of Health and the nonprofit organization has not received any funding from TDH for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed "tear-out" sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by TDH staff.

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\*Chairman of the Board Signature/Date

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\*President or Executive Director Signature/Date

\*If the signed original of this form has been provided to the Texas Department of Health during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.



**Texas Department of Health**  
**Bureau of HIV & STD Prevention**  
**FORM L**

## **HIV CONTRACTOR ASSURANCES**

### **1. ADVOCATE AND PROMOTE**

The applicant agency assures that it does not advocate or promote conduct that violates state law, in compliance with the HIV Services Act, Texas Health and Safety Code, Section 85.011, as follows:

"Grants may not be awarded to an entity or community organization that advocates or promotes conduct that violates state law. This subsection does not prohibit the award of a grant to an entity or community organization that provides accurate information about ways to reduce the risk of exposure to or transmission of HIV."

### **2. CONFIDENTIALITY**

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Texas Department of Health that confidentiality of all records shall be maintained. No information obtained in connection with the examination, care, or provision of programs or services to any person with HIV shall be disclosed without the individual's consent, except as may be required by law, such as for the reporting of communicable diseases. Information may be disclosed in statistical or other summary form, but only if the identity of the individuals diagnosed or provided care is not disclosed.

We are aware that the Health and Safety Code, §81.103, provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law. Furthermore, all employees and volunteers who provide direct client care services or handle direct care records wherein they may be informed of a client's HIV status or any other information related to the client's care, are required to sign a statement of confidentiality assuring compliance with the law. An entity that does not adopt a confidentiality policy as required by law is not eligible to receive state funds until the policy is developed and implemented.

### **3. CONFLICT OF INTEREST**

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Texas Department of Health that no person who is an employee, agent, consultant, officer, board member, or elected or appointed official of this agency, and, therefore, in a position to obtain a financial interest or benefit from an activity, or an interest in any contract, subcontract, or agreement with respect thereto, or the proceeds thereunder, either for himself or herself or for those with whom he or she has family or business ties, during his or her tenure or for one year thereafter shall participate in the decision making process or use inside information with regard to such activity. Furthermore, this agency will adopt procedural rules which require the affected person to withdraw from his or her functions and responsibilities or the decision-making process with respect to the specific assisted activity from which they would derive benefit.

### **4. TUBERCULOSIS COLLABORATION**

The applicant agency assures the TDH that it maintains collaborative efforts with local Tuberculosis (TB) Control programs in order to insure that HIV and TB treatment and prevention services are provided to persons at risk of HIV and TB.

## 5. DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing a drug-free awareness program to inform employees about-
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will-
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
- (e) Notifying the agency within ten days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction;
- (f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted-
  - (1) Taking appropriate personnel action against such an employee, up to and including termination; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

## 6. POLICIES OF THE BUREAU OF HIV & STD PREVENTION

The applicant agency assures the TDH that it will abide by all policies of the Bureau of HIV and STD Prevention which apply to the programs being provided. A list of policies applicable to all HIV and STD contractors is provided at the Bureau website at <http://www.tdh.state.tx.us/hivstd/policy/default.htm>.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Applicant Organization	

<p style="text-align: center;"><b>Texas Department of Health</b> <b>Bureau of HIV &amp; STD Prevention</b> <b>FORM M</b></p>
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**CONTRACTOR ASSURANCE REGARDING  
PHARMACY NOTIFICATION**

To ensure that pharmacies providing prescriptions to HIV services clients do not fill medications on deceased clients, the applicant agency provides assurance to the Texas Department of Health that it will notify the client's pharmacy when a client dies.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	

Texas Department of Health  
Bureau of HIV & STD Prevention  
Form N

**Assurance Regarding HIV/STD Clinical Resources Division Standards for  
Clinical and Case Management Services**

This agency assures the Texas Department of Health that it will comply with HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services (Standards) as promulgated by the Bureau of HIV & STD Prevention. The Standards are available at [www.tdh.state.tx.us/hivstd/clinical/pdf/stvs3\\_01.pdf](http://www.tdh.state.tx.us/hivstd/clinical/pdf/stvs3_01.pdf)

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	

## FORM E: PERFORMANCE MEASURES

*In the event a contract is renewed, applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this renewal application. **Additional pages may be attached if needed.***

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## FORM E: PERFORMANCE MEASURE Guidelines

Applicant shall include the performance measures in the renewal application along with the proposed target levels of performance for each measure. The proposed target levels of performance and reporting frequency will be negotiated and agreed upon by applicant and TDH if applicant is selected to negotiate a contract.

Applicants shall write performance measures for project objectives and proposed target levels of performance for each measure. The proposed measures and levels of performance will be negotiated and agreed upon by applicant and TDH if applicant is selected to negotiate a contract.

Performance measures shall be specific, measurable, time-phased, and feasible. Performance measures quantify program outcomes and outputs, the number of such outputs to be performed, and the efficiency with which they will be performed. Performance measures also define the applicant's obligations in order to meet its contract requirements.

Performance measures are defined as outcome, output, efficiency, and explanatory measures. A well-written measure includes the following components: who will deliver the service(s) and their qualifications (as appropriate); a deliverable (a product or service and how much); a schedule/time frame; and a standard of performance. The following table provides a guide for developing the different types of performance measures:

Type	Measure	Example
<b>Outcome</b>	<i>measures the actual impact or public benefit of an entity's actions</i>	<i>% of clients rehabilitated % decline in inappropriate ER usage % decline in school absences</i>
<b>Output or Process</b>	<i>counts the goods/services provided</i>	<i># of clients served # of clinic sessions</i>
<b>Efficiency</b>	<i>measures the cost, unit cost, or productivity associated with a given outcome or output</i>	<i>average cost per client served average time per visit</i>
<b>Explanatory</b>	<i>shows the resources used to produce services and display factors that affect entity performance</i>	<i># of clients eligible for services # and type of health services presently available # of new partnerships developed</i>

## **FORM F: WORK PLAN**

*Applicants shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. **Additional pages may be attached if needed.***

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## **FORM F: WORK PLAN Guidelines**

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. The work plan shall address any changes to the needs and the problems identified in the community assessment for improving health status. The plan shall:

1. Summarize the proposed services, population to be served, location (counties to be served), etc. Also address the following two questions: a) Will you serve individuals from counties outside your stated service area? b) If you are requesting funds to increase your total project budget (all sources), how will this impact your overall agency program goals.
2. Describe delivery systems, and any changes to: workforce (attach organizational chart if changed from original competitive RFP application), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. "What resources do we have to perform the project, who will deliver services and how will they be delivered?"
3. Describe any changes to how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur.
4. Describe any changes to coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided.
5. Describe any changes to applicant's ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, and other means to ensure accessibility for the defined population).
6. Describe any changes to applicant's internal Quality Assurance/Quality Improvement (QA/QI) process utilized to monitor services. Identify any changes to staff who use them and who is responsible for ensuring they are updated. The description shall include the following 1) role of the QA/QI Committee; 2) Medical Director's involvement in the QA/QI activities; 3) activities utilized to identify trends of needed improvement and the frequency of those activities; 4) activities to ensure correction and follow-up to findings identified; 5) utilization and frequency of client satisfaction surveys; 6) system utilized to identify and monitor adverse outcomes (sentinel events); 7) process for identifying outcome measures; and 8) process utilized to develop protocols and Standing Delegation Orders (SDOs).
7. Describe how Needs Assessment tools are being utilized, and how your service area plans to incorporate Needs Assessment results to improve and focus service delivery.